WEIGHT CONTROL QUESTIONNAIRE

1: How did you hear about us?

News       Google       Word of mouth       Friend       Patient       Doctor

2: What is your weight loss goal? ________ Each week? ________ 6 months? ________

3: If you don’t lose the weight as you anticipate, how will you react? ________________

4: What size clothing are you currently wearing? __________________

5: Goal clothing size? ________________

6: Do you currently exercise? ________________ How much? ________________

7: How much water do you drink daily?

8: On an average day, are you: sedentary    mildly active    moderately active    very active

9: Are you currently, or have you recently tried a weight loss program? If so, what is it about that program that is not working for you?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

10: What current issues are making it difficult for you to reach your goal weight (e.g. cravings, portion control, education on foods to eat)?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

11: What do you expect from us as your medical counselors?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
12: How will reaching your weight loss goal change your life?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

13: What do you expect to do to maintain your weight, once you have reached your goal?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

14: Will you continue to watch your food intake? ____________ Exercise? ________________

15: Do you have any other expectations not discussed in this questionnaire? Please describe.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

______________________________________________________ ______________________
Signature        Date
Patient Information Form

Patient Name: ___________________________ Preferred Language: ___________________________

Address: ___________________________ City: __________ State: ________ Zip: ________

Home Phone: ___________________________ Cell Phone: ___________________________ Carrier: ___________________________

DOB & Age: ___________________________ Race: ___________________________ Ethnicity: [ ] Hispanic  [ ] Non-Hispanic

Sex: ___________________________ SSN: ___________________________ Email Address: ___________________________

Employer
Name: ___________________________ Address: ___________________________

Occupation: ___________________________ Work Phone: ___________________________

Who is your primary care physician? ___________________________

How did you hear about our practice?
[ ] Patient Referral: ___________________________  [ ] Dr. Referral: ___________________________
[ ] Friend: ___________________________  [ ] Google
[ ] Other: ___________________________

What is the nature of your visit? ___________________________

Is this an accident or work injury?  [ ] Yes  [ ] No

Please provide insurance information:

Emergency Contact

Name: ___________________________ Relationship:  [ ] Spouse  [ ] Parent/Guardian  [ ] Other: ___________________________

Home Phone: ___________________________ Cell Phone: ___________________________ Work Phone: ___________________________

Primary Insurance

Name: ___________________________ Policy #: ___________________________ Group ID: ___________________________

Address: ___________________________ City: ___________________________ State: ________ Zip: ________

Insurance Card Holder Name: ___________________________ Relationship to Patient:  [ ] Self  [ ] Spouse  [ ] Child  [ ] Dependent
[ ] Card Holder’s Date of Birth: ___________________________

Secondary Insurance
Name: ___________________________ Policy #: ___________________________ Group ID: ___________________________

Address: ___________________________ City: ___________________________ State: _______ Zip: _______

Insurance Card Holder
Name: ___________________________ Relationship to Patient:  □ Self  □ Spouse  □ Child  □ Dependent  Card Holder’s
Date of Birth

Assignment and Release

I, ___________________________ ___________________________, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____________________________ _________________
Signature of Insured / Guardian Date

Medical History from ThedaCare

☐ Yes  ☐ No

Are you a patient in the ThedaCare system? If “no”, proceed to the next section I - Surgery and Anesthesia History. If “yes”, please answer the next question.

☐ Yes  ☐ No

FVPS can access your medical history from the ThedaCare system so that you do not have to fill out the following medical history. Do you consent to allowing us to access your medical history from ThedaCare? If you answer “yes”, you can skip the questions on the next two pages. Please initial here if yes.

Section I: Surgery and Anesthesia History

1. Have you ever had surgery?  □ No  □ Yes, please describe:

________________________________________________________________________

________________________________________________________________________

2. Do you have a blood relative who had anesthesia complications of any kind?  □ No  □ Yes, please describe:

________________________________________________________________________

Section II: Specific Medical History

1. Are you pregnant?  □ No  □ Yes  Height: _______ Weight: _______

Have you or do you still have:

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<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Description</th>
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<tbody>
<tr>
<td>2. Anemia</td>
<td>□</td>
<td>□</td>
<td></td>
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<tr>
<td>3. Asthma</td>
<td>□</td>
<td>□</td>
<td></td>
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<tr>
<td>4. Emphysema</td>
<td>□</td>
<td>□</td>
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<tr>
<td>5. Bleeding tendency</td>
<td>□</td>
<td>□</td>
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<tr>
<td>6. Blood clots</td>
<td>□</td>
<td>□</td>
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<td>7. Cancer</td>
<td>□</td>
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<td>8. CHF</td>
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<tr>
<td>9. COPD</td>
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<td>□</td>
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<tr>
<td>10. Diabetes</td>
<td>□</td>
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</table>
11. High Blood Pressure
12. Heart disease
13. Hepatitis
14. Herpes/Cold Sores
15. Kidney disease
16. Melanoma
17. Migraine headaches
18. Stroke
19. Thyroid disease
20. Problem Scarring
21. Have you been advised to or had psychiatric care?
22. Vein problems, such as venous reflux disease
23. Others Not Listed

Section III: Social History

1. Do you smoke? □ No □ Yes, how much?
   □ No □ Yes, how much?
2. Do you drink? □ No □ Yes, how much?
   □ No □ Yes, how much?
3. Do you have children? □ No □ Yes, how many?
   □ No □ Yes, how many?
4. Do you exercise? □ No □ Yes, how much?
   □ No □ Yes, how much?

Section IV: Family History

Have any blood relatives had any of the following? No Yes Description
1. Asthma □ □
2. Bleeding Tendency □ □
3. Blood Clots □ □
4. Cancer □ □
5. Chronic Lung Disease □ □
6. Depression □ □
7. Diabetes □ □
8. Heart Disease □ □
9. High Blood Pressure □ □
10. Kidney Disease □ □
11. Melanoma □ □
12. Mental Illness □ □
13. Migraine Headaches □ □
14. Obesity □ □
15. Stroke □ □
16. Thyroid Trouble □ □
Are you taking any medications, vitamins or herbal supplements?  □ No  □ Yes, please list:

<table>
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<tr>
<th>Name of Medication</th>
<th>Strength (mg)</th>
<th>How many times a day?</th>
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**Section VI: Allergies and Sensitivities**

Are you allergic to any medications or local anesthesia?  □ No  □ Yes, please list:


**Section VII: Women Only**

Date of last mammogram: __________________________ Number of pregnancies: __________________________

Do you do regular breast self-exams?  □ Yes  □ No
Do you breast feed?  □ Yes  □ No
Breast lump or discharge?  □ Yes  □ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: __________________________ Date: __________________________
Print Name: ________________________________
DOB: __________________

Consent to Communicate

Patient: ________________________________

Please mark the ways that you consent to us communicating with you:

<table>
<thead>
<tr>
<th>Method</th>
<th>Ok to Leave Voicemail</th>
<th>Ok to Leave Message with Another Person</th>
<th>Preferred Contact Method(s)</th>
<th>Best Time to Call*</th>
</tr>
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<tbody>
<tr>
<td>Call Work Phone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call Cell Phone</td>
<td></td>
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<tr>
<td>Call Home Phone</td>
<td></td>
<td></td>
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<tr>
<td>Send Email</td>
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☐ Email Appointment Reminders
☐ Email Office Specials
☐ Email Medical Info – Please keep in mind that communications via email over the internet are not secure and are not HIPAA compliant. Although it is unlikely, there is a possibility that information in an email can be intercepted and read by other parties besides the person to whom it is addressed.

☐ Send Regular Mail
Mail to which Address: ☐ Home ☐ Other (please list):

☐ Send Text Message. Carrier name:
☐ Text Appointment Reminders
☐ Text Office Specials

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it’s ok to leave a message with another person, please list them:

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Relationship</th>
<th>OK to Release Results</th>
<th>Any Comments</th>
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☐ Yes ☐ No

☐ Yes ☐ No

Signature: ________________________________ Date: __________________

- Page 5 of 8 -
WRITTEN ACKNOWLEDGMENT OF RECEIPT

I, ______________________________________, acknowledge that I have received the written Notice of Privacy Practices from Fox Valley Plastic Surgery.

________________________________________

Patient or Personal Representative Signature: ____________________________ Date: __________

If Personal Rep, describe relationship

________________________________________

☐ The patient’s condition prohibits the individual from signing an acknowledgement at the time. It will be obtained as reasonably practicable after the patient’s condition improves.

☐ Acknowledgment was unable to be obtained. Reason:

________________________________________________________________________

________________________________________________________________________

EMPLOYEE SIGNATURE: ____________________________
FINANCIAL POLICY

Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly. We will make every effort to avoid a misunderstanding.

ALLOWABLE FORMS OF PAYMENT

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts payment by cash, check and credit cards from Visa, Mastercard, Discover and American Express.) We also offer patient financing through Care Credit.

INSURANCE/CO-PAYS/DEDUCTIBLES

As a courtesy to you, we will file your insurance claims for you. Our office accepts assignment of benefits for many insurance companies. However, we are not participating providers with all of them, so please inquire as to whether we are with your plan. We will verify your coverage and will estimate what your patient responsibility will be through co-pays, deductibles and co-insurance. You are responsible for paying these out of pocket expenses before any surgery or office procedure is done. Your health care policy is a contract between you and your insurance company. It is ultimately your responsibility to pay for all services provided by Fox Valley Plastic Surgery.

INJURIES/ACCIDENTS

If your injury or accident involves litigation, a letter of protection needs to be obtained from the attorney involved.

BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has paid unless other arrangements have been made with our Financial Supervisor. If payment is not received in 90 days, your account will be turned over to a collection agency.

Thank you for understanding our Financial Policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read the above Financial Policy. I understand and agree to this.

[Signature]
[Date]

I consent to having before and after photographs taken of me or parts of my body. These will be used for office and insurance prior authorizations purposes only.

[Signature]
[Date]

I hereby authorize my insurance benefits to be paid directly to FVPS realizing I am responsible to pay any and all charges that exceed or that is not covered by insurance. I authorize the release of pertinent medical information to insurance and workers comp carriers.

[Signature]
[Date]
I hereby consent to and authorize the use and reproduction by Fox Valley Plastic Surgery, or anyone authorized by them, of any and all photographs, electronic images or video footage of me taken by FVPS, or that FVPS has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the FVPS website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of FVPS.

I understand that the Images will not be identified by my name, but that such Images may reveal my identity. I understand and accept these terms.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless FVPS and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Fox Valley Plastic Surgery.

I hereby warrant that I am at least eighteen years old, and competent to contract in my own name insofar as the above is concerned.

The purpose of this form is to obtain my prior written consent so that Fox Valley Plastic Surgery may photograph or film me for one or more of the following purposes listed below for which I do hereby consent. Initial all that apply:

_________ Medical Use: Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians, or in a professional presentation or journal publication

_________ Office Use: Use or disclosure of image for marketing or advertising purposes and patient education within the office

_________ Internet Use: Use or disclosure of image for marketing or advertising purposes and patient education via print, visual and electronic media

Photo Limitations: ______________________________________________________________

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

<table>
<thead>
<tr>
<th>Patient’s Signature</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Patient’s Printed Name</th>
<th>Date</th>
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